Department of Medical Assistance Services
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MEDICAID MEMO

TO: Residential Treatment Centers (Level C); Freestanding Psychiatric Hospitals that Provide Services to Individuals Under 21 Years of Age; General Acute Care Hospitals; Physicians; Licensed Psychologists; Clinical Psychologists; Licensed Professional Counselors; Clinical Nurse Specialists – Psychiatric Only; Nurse Practitioners – Psychiatric Only; State Health Department; Federally Qualified Health Center; Rural Health Clinic; Mental Health, Mental Retardation, Substance Abuse Clinics (FAMIS); Licensed Clinical Social Workers; Licensed Social Workers, Out-of-State Physicians; Licensed Marriage and Family Therapists; Substance Abuse Practitioners; Optometrists; Opticians; Nutritionists; Podiatrists; Audiologists; Hearing Aid Providers; Physical Therapists; Occupational Therapists; Speech-Language Pathologists; DME/Supply Providers; Prosthetics Providers; Independent Labs; Prescribing Providers; Pharmacists; Radiology Providers; Providers of MRIs; Respiratory Therapists; Ambulatory Surgical Centers; Emergency Transportation Providers; Transportation Providers; and Managed Care Organizations Participating in the Virginia Medical Assistance Programs

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services

MEMO: Special

DATE: June 9, 2014

SUBJECT: New Requirements for Billing of Services Provided Under Arrangement Furnished to Medicaid Members Under the Age of 21 in Residential Treatment Centers – Level C or Freestanding Psychiatric Hospitals

The U.S. Court of Appeals issued a decision on May 8, 2012 in a lawsuit brought by the Department of Medical Assistance Services (DMAS) challenging a federal audit finding related to DMAS reimbursements for services provided to members under the age of 21 in residential treatment centers ("RTC – Level C") and freestanding psychiatric hospitals (both state and private). This also applies to EPSDT specialized contracts for residential treatment facilities. In this memo, these facilities will be referred to as Inpatient Psychiatric Facilities or IPFs.

In order to comply with the court decision and federal law, the 2012 and 2013 Appropriations Acts require that DMAS modify the reimbursement process for certain services furnished to Medicaid members who are under the age of 21 and who are residing in an IPF. DMAS has promulgated emergency regulations to implement the General Assembly's mandate on this issue; they are scheduled to go into effect July 1, 2014. These emergency regulations are publicly accessible on the Virginia Regulatory Town Hall at the following address: http://townhall.virginia.gov/L/viewstage.cfm?stageid=6572.

The services that are affected are "services provided under arrangement" with the IPF, including physician and other health care services that are furnished to children in an IPF and billed separately from the IPF per diem. Services that can be provided under arrangement with an IPF are listed below for each provider type. In order for DMAS to continue to reimburse these services separately from the per-diem rate paid to IPFs, the Centers for Medicare and Medicaid Services (CMS) requires that the IPF: 1) arrange for and oversee the provision of all services; 2) maintain all medical records of services provided under arrangement furnished to the member

residing in the IPF; 3) ensure that each member residing in an IPF has a comprehensive plan of care that includes services provided under arrangement; and 4) ensure that all services, including services provided under arrangement, are furnished under the direction of a physician.

This Medicaid Memorandum is an Agency Guidance Document and provides specific details concerning how DMAS interprets and applies 12 VAC 30-50-130; 12 VAC 30-60-25; 12 VAC 30-70-201, 70-321, 70-415 and 70-417; 12 VAC 30-80-21; and 12 VAC 30-130-850 through 130-890. This memo explains how DMAS will implement the CMS requirements and the emergency regulations effective July 1, 2014. On the effective date of the regulations, DMAS will only reimburse providers who furnish services to members residing in an IPF when they comply with the requirements outlined in this memo including the billing requirements at the end of this memo. If these requirements are not met, DMAS will not reimburse for these services and providers may not charge members directly. These requirements will apply to both in-state providers and out-of-state providers. These requirements also apply across all contractors (Magellan, DentaQuest, LogistiCare) who administer claims on behalf of DMAS and reimburse for services furnished members residing in IPFs.

IPFs and providers of services under arrangement must be Medicaid enrolled providers. Currently enrolled providers do not need to make any enrollment changes. IPF providers and the providers of services under arrangement will need to make operational changes prior to implementation. There will be no change to the amount of the per-diem reimbursement paid to IPFs, and no changes to the amount of reimbursement paid to providers of services under arrangement. All existing service authorization requirements remain in effect for both the IPF facilities and for services provided under arrangement.

IPF Requirements for Direct Reimbursement to Providers of Services Provided under Arrangement

DMAS will reimburse services provided under arrangement separately from the per-diem rate paid IPFs only if the IPF meets all of the following requirements:

1) As required by regulations already in existence (42 CFR 441.155; 12 VAC 30-130-890; 42 CFR 456.180; and 12 VAC 30-50-130), each initial and comprehensive plan of care must be specific to meet each child's medical, psychological, social, behavioral and developmental needs.
2) Each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of the service provided under arrangement, any service that the individual needs while residing in an IPF, and that is furnished to the member by a provider of services under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review. Services provided under arrangement must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement. IPFs should begin preparations now to include routine or expected services provided under arrangement in each plan of care.

3) Each initial and comprehensive plan of care must document the prescribed frequency and circumstances under which the services provided under arrangement shall be sought.

4) Each IPF must document a written referral for each service provided under arrangement, and must maintain a copy of the referral in the member's medical record at the facility. The provider of the service under arrangement must also maintain a copy of the referral in the member's medical record.

The referral must be consistent with the plan of care. A physician order will meet the requirement for a referral. For pharmacy services, the referral is the prescription. The prescribing provider must be employed or have a contract with the facility. Referrals should not be documented unless the provider has accepted the referral.

5) Providers of services under arrangement must either be employees of the IPF or, if they are not employees of the IPF, they must have a fully executed contract with the IPF in advance of provision of the service, with the exception of emergency services. For emergency services, the contract must be executed before the provider of emergency services bills DMAS for the emergency services. IPFs should begin preparations now to contract with usual providers of services under arrangement who are not employees of the IPF.

   The contract must include the following: 1) if the provider of services under arrangement accepts a referral, it agrees to include the NPI of the referring IPF on its claim for payment; and 2) the provider of services under arrangement agrees to provide medical records related to the member residing in the IPF upon request. A fully executed contract requires that a representative of the IPF and a representative of the provider of services under arrangement signs the contract and includes their name, title, and date. A letter of understanding or letter of agreement will meet the requirement for a contract, provided that both the IPF and provider of services under arrangement sign the letter.

6) Each IPF must maintain medical records from the provider of services under arrangement in the individual's medical record at the facility. These may include admission and discharge documents, treatment plans, progress notes, treatment summaries and documentation of medical results and findings. These records must be requested in writing by the IPF within seven (7) calendar days of discharge from or completion of the service provided under arrangement. If the records are not received from the provider of services under arrangement within 30 days of the initial request, they must be re-requested.

If there is the potential for retroactive Medicaid eligibility, the IPF should comply with these requirements so that the provider of services under arrangement can bill Medicaid after eligibility is confirmed.

<u>Providers of Services Under Arrangement: Requirements for Direct Reimbursement</u>

DMAS or its contractors will not reimburse providers for services furnished to Medicaid members residing in an IPF unless: 1) the provider is employed by the IPF or contracted with the IPF and 2) the provider has a referral from the IPF for the services furnished. The referral should be documented in the records of the provider of services under arrangement. The provider must follow special billing instructions described below.

The requirements above are in addition to all other existing requirements for services. For example, providers of services under arrangement must still obtain service authorization for services that otherwise require service authorization.

Providers should always verify Medicaid eligibility prior to furnishing services. If the member is eligible but has an "IM" indicator in the level of care, providers should not furnish non-emergency services until they complete the requirement for contracting with and have a referral from the IPF. The IM indicator in the level of care is available through multiple methods: the Automated Response System (ARS), the Virginia Medicaid Web Portal, Medicall or a 271/272 electronic transaction.

Special Instructions for Dental, Pharmacy, Emergency Services, Non-Emergency Transportation and Inpatient Acute Care Services

Dental services for Medicaid members are provided through Smiles For Children (SFC) and are reimbursed by the Department's Dental Benefits Administrator (DBA), DentaQuest. IPFs that currently arrange for dental services should continue to do so based on the member's Plan of Care. IPFs must have a contract with a SFC participating dentist and must provide a referral to that dentist's office when the appointment is made for one of their residents/patients. The IPF shall provide the name of its contracted dentist to the Department or DentaQuest upon request.

Pharmacies must have a contract with the IPF. DMAS will use the prescribing NPI as the referral NPI. The prescription can serve as the referral document. The prescribing provider must be an employee or contractor of the IPF.

IPFs should include emergency services in the plan of care and contract in advance with the usual providers of emergency services. However, if the IPF uses a non-contracted provider for emergency services, the IPF may contract with the emergency services provider after the fact. The emergency services provider must have a contract in place with the IPF provider prior to billing DMAS. A referral is required for emergency services, and the emergency services provider must include the NPI of the IPF in the referring provider locator on the claim for payment.

Some providers are affiliated with hospitals but provide outpatient services as a separate billable item from the hospital charge (such as radiologists, pathologists, anesthesiologists, etc.). The acute-care hospital shall be responsible for providing the referral NPI of the IPF to these "hidden" providers. These "hidden" providers must be addressed in the contract between the IPF and the hospital that provides the emergency services.

IPFs that use LogistiCare for medical transportation must have a contract with Logisticare which allows non emergency transportation to be provided as a service provided under arrangement. When the member residing in the IPF needs transportation, the IPF should contact the LogistiCare facility number (866-679-6330) or use the LogistiCare online request system (https://facility.logisticare.com) in order to arrange transportation services. This request for transportation will be considered the referral. RTC-Level C providers must 1) inform LogistiCare that they are an RTC-Level C provider; and 2) provide LogistiCare with the RTC-Level C NPI number to use as a referral NPI on the transportation encounter that is submitted to DMAS.

Inpatient admissions to hospitals for treatment of acute care conditions do not require a referral or arrangement from the IPF. However, the IPF must report all patient discharges from their facility to Magellan within one business day. Failure to notify Magellan will result in any claims associated with the inpatient acute care stay being denied. Upon readmission to the IPF, the member will not require a new Certificate of Need unless the existing Certificate of Need authorizing the previous stay at the facility had expired during the member's inpatient placement.

Services Provided Under Arrangement by Provider Type

See chart below for services provided under arrangement that may be billed separately for each provider type, provided that the requirements discussed above are met. (Certain services are included in the per-diem rates for

each provider type, which results in the differences shown in the list below.) No other services may be billed for members under age 21 residing in IPFs.

Services Provided Under Arrangement	Residential Treatment Centers Level C	Private Freestanding Psychiatric Hospitals	State Freestanding Psychiatric Hospitals
Physician Services	Yes	Yes	No
Other medical and psychological services including those furnished by licensed mental health professionals and other licensed or certified health professionals (i.e. oral surgeons, nutritionists, podiatrists, respiratory therapists, substance abuse treatment practitioners)	Yes	Yes	No
Outpatient Hospital Services	Yes	Yes	No
Pharmacy services	Yes	No	Yes
Physical therapy, occupational therapy and therapy for individuals with speech, hearing or language disorders	Yes	Yes	No
Laboratory and radiology services	Yes	Yes	No
Durable medical equipment (including prostheses/orthopedic services and supplies and supplemental nutritional supplies)	Yes	No	No
Vision services	Yes	Yes	No
Dental and orthodontic services	Yes	Yes	No
Non-Emergency Transportation services	Yes	Yes	No
Emergency services (including outpatient hospital, physician and transportation services)	Yes	Yes	Yes

Utilization Review/Audit

If the IPF fails to comply with any one of the requirements listed above, DMAS may retract the per diem reimbursement made to the IPF on behalf of a member during the period of non-compliance.

An IPF may arrange for services for members with providers who are not enrolled with DMAS. As long as these services are included in the plan of care, the IPF is in compliance. The IPF should not arrange for services with a DMAS enrolled provider without either an employee relationship or a contract as this could result in a retraction to the per diem during an audit.

Special Rules for Services Funded Solely through the Comprehensive Services Act (CSA) or Other Payers for Medicaid Members in an RTC-Level C

The RTC-Level C facility has the responsibility to arrange and oversee all services provided under arrangement for Medicaid members residing in the facility, even if the facility's service is reimbursed entirely by CSA or another payer. In order for Medicaid to pay for services provided under arrangement, the facility and the provider of services under arrangement must meet all the requirements outlined in this memo and other guidance from DMAS to arrange and oversee such services. Providers of services under arrangement will need to submit the referring NPI of the facility on all claims. Magellan service authorization is not required for RTC-Level C services reimbursed by non-Medicaid payers, but RTC-Level C providers are required to notify Magellan when a Medicaid member is residing in the RTC and there is a non-Medicaid payer so that the Medicaid member is assigned the correct benefit plan including the "IM" indicator which defines the member's

level of care. RTC-Level C providers may call 1-800-424-4536 and ask to speak to the Magellan residential team supervisor or one of the residential team members who will record admissions and discharges in the member's record.

Billing Requirements

When a provider of services under arrangement submits a claim for their services to DMAS or one of its contractors (Magellan, DentaQuest, Logisticare), the NPI of the referring IPF must be submitted on the claim. The claim will deny or be retracted if no referring NPI is submitted. This referral number will be required as indicated below:

CMS-1500: Locator 17 - Name of Referring RTC-Level C or the free standing psychiatric hospital
Locator 17b - Enter the National Provider Identifier (NPI) of the RTC-Level C or the free standing psychiatric hospital.

UB 04: Locator 78 Other Provider Name and Identifiers - Enter the NPI for the RTC-Level C or the free standing psychiatric hospital.

EDI 837 Professional:

Loop	Segment	Data Element	Comment
2310A-Referring Provider Name	NM1	NM109-Referring Provider Identifier	Submit the Referring IPF Provider's NPI in this field.
2310A – Referring Provider Name	NM1	NM108 – Referring Provider Identification Code	Use 'XX' for NPI

EDI 837 Institutional:

Loop	Segment	Data Element	Comment
2310F- Referring Provider Name	NM1	NM101 – Entity Identifier Code	Should always be 'DN' for the NPI of referring provider
2310 F – Referring Provider Name	NM1	NM108 – Identification Code Qualifier	Use 'XX' for NPI
2310F- Referring Provider Name	NM1	NM109 – Identification Code	Submit the Referring IPF Provider's NPI in this field.

Training and Questions

Training was provided in Roanoke on May 7, 2013 and Richmond on May 14, 2013. A recorded WebEx for both facilities and providers of services under arrangement was posted to the learning network section of the DMAS website; an additional two WebEx trainings are planned for the morning and afternoon of June 16, 2014 and also during the Friday afternoon Magellan Provider calls on June 20th and June 27, 2014. Please refer to the Magellan website at http://www.magellanofvirginia.com/ for more information about the Friday Network calls. A fact sheet has been posted on the behavioral health page of the DMAS website and FAQs will soon follow. The link for this information is at http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx. Additional questions can be directed to the DMAS Behavioral Health Unit at 804-786-1002 or email to CMHRS@dmas.virginia.gov. Behavioral health providers with billing questions can also call Magellan at 800-

424-4046 or email VAProviderQuestions@MagellanHealth.com. Non-behavioral health providers with billing questions can call the HELPLINE at 800-552-8327 (804-786-6273 Richmond area or out of state).

Managed Care Organizations (MCO)

Medicaid members who are placed in a DMAS authorized RTC-Level C are not eligible to participate in the Department's MCO program. *(In the event that an MCO member requires placement in a RTC Level C facility, the member will be disenrolled from the MCO to fee-for-service (FFS) coverage as part of the RTC Level C service authorization process through Magellan).* Additionally, Medicaid members who are admitted to a freestanding psychiatric hospital under FFS coverage will remain in fee-for-service until discharged. For more information see "Hospitalized at the time of MCO enrollment" on the DMAS website at: http://www.dmas.virginia.gov/Content_atchs/mc/mc-mdl2_hsptlzd.pdf.

Coverage for services rendered to Medicaid MCO enrolled members in a freestanding psychiatric hospital may be available through the MCO contract. In order to be reimbursed for services provided to MCO enrolled members, freestanding psychiatric hospital providers must follow their respective contract(s) with the MCO. The MCO may utilize different service authorization, billing, and reimbursement guidelines than those described for Medicaid FFS members. For more information, please contact the MCO directly. Additional information about the Medicaid MCO program, including MCO contacts, can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

FAMIS

IPF services are not covered for members enrolled in the FAMIS program either in FFS or in an MCO.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.